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February 4, 2007

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-2237-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Interim Final Rule with Comment Period
Medicaid Program: Optional State Plan Case Management Services
File code CMS-2237-IFC

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS), the Arizona state agency that administers Arizona's Medicaid program, I am pleased to have the opportunity to submit comments regarding the interim final regulations for case management services published at 72 Fed. Reg. 68,077 (December 4, 2007). AHCCCS is requesting that the interim final rule be amended to clarify that the regulations do not apply to medical management activities conducted by Medicaid managed care entities even if the managed care "case manager" performs some or all of the same functions encompassed within the regulatory definition of case management so long as the activity is not claimed or encountered as "medical assistance" under section 1915(g) of the Social Security Act. Specifically, we are requesting that the regulations clearly indicate that managed care "case managers" are not subject to the provisions that prohibit case management from being used as a method to restrict access to care and that medical management activities by a managed care organization do not represent a duplication of any case management services authorized and provided as medical assistance under section 1915(g) of the Act and the State Plan.

Background

As noted in the preamble to the interim final rule, Congress, through section 1905(a)(19) of the Act, authorized states the option to offer "case management," as defined in section 1915(g) of the Act, as "medical assistance" through states' Medicaid programs. Case management services are eligible for federal financial participation if the State has elected to offer the service as indicated in an approved State Plan. However, to avoid unnecessary confusion of managed care enrollees (and possible litigation by their advocates), Arizona believes that certain statements in the Legislative History regarding section 1915(g)(1) require clarification.

With respect to free choice of providers, CMS states that section 9508 of COBRA "required that there be no restriction on free choice of providers of case management services that would violate section 1902(a)(23) of the Act." 72 Fed. Reg. at 68,078. The relevant sentence in section 1915(g)(1) reads: "The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23)" (emphasis added). Clarification is required in three respects. First, it is important to note that section 1902(a)(23) permits restricting free choice of providers as part of a state's implementation of managed care through the State Plan option authorized by section 1932(a). Second, it is important to clarify that the quoted language in section 1915(g)(1) does not supersede the Secretary's discretionary authority, under section 1115(a) of the Act, to waive states from compliance with the requirement of section 1902(a)(23) regarding free choice of providers. As you may know, the Secretary has, in fact, provided Arizona with such a waiver. As part of that waiver, Arizona, through its capitation payments, requires managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) under contract with Arizona to perform medical management activities, which are performed in part through personnel referred to as case managers. Third, and most significantly, Arizona understands the position of CMS, as articulated in this interim final rule, to be that medical management services provided as part of a Medicaid managed care

system are not "case management services under this subsection [1915(g)]" and, as such, are not subject to the requirements of this interim final rule.

Medical management is an integral function of any effective managed care system. With respect to enrollees with chronic conditions and/or a high-level need for complex care, managed care organizations frequently perform medical management (at least in part) through persons referred to as "case managers." In addition to assessing need, creating plans of care, and arranging for and following up on the enrollee's medical care, one of the managed care case manager's primary roles is evaluating the medical necessity and cost effectiveness of alternative plans of care (including services specifically requested by the enrollee or by a health care provider on the member's behalf). Indeed, it is a routine part of a managed care case manager's duties to deny access to care or, as appropriate and consistent with 42 C.F.R. § 438.210(b)(3), refer potential denials of care to a health care professional with appropriate clinical expertise. Individualized care management by the managed care entity has the potential not only to control costs but also to produce better health outcomes for enrollees through the managed care manager's utilization of evidence-based practices and by ensuring the enrollee's follow up on referred care. Indeed, 42 C.F.R. § 438.208 requires that managed care entities assess enrollee's needs, establish plans for their care, and coordinate delivery of that care. This is an essential feature of any successful managed care program.

In addition to management of traditional medical services, managed care entities also case manage certain covered services that are not strictly medical services and are more aptly described as "social" services. These services include such things as non-emergency transportation and personal care, homemaker, and respite services for enrollees who are eligible for and receive home and community based services under Arizona's section 1115 waiver. See 42 C.F.R. §§ 440.170(a) and 440.180(b). For the reasons stated above, it is equally important to the success of a managed care system that this care be appropriately assessed, planned, and managed in collaboration with the enrollee.

Finally, these types of medical management services are as important, if not more so, for enrollees in an institutional setting. As such, it would be detrimental to effective managed care if the limitation in the interim final rule regarding case management for persons in such settings were applied to managed care activities.

The preamble to the rule supports Arizona's conclusion that CMS does not intend this interim final rule to apply to medical management activities by managed care entities. First, the preamble consistently refers to case management services authorized by sections 1905(a)(19) and 1915(g) of the Act- that is, to those provisions that authorize case management as a service covered under the State Plan without reference to services authorized under a section 1115 waiver or managed care activities under section 1932 of the Act. 72 Fed. Reg. at 68,078 ("The regulations set forth in this interim final regulation implement . . . the case management services provisions authorized by sections 1905(a)(19) of the Act and 1915(g) of the Act"); 72 Fed. Reg. at 68,079 ("This rule implements in Federal regulations the statutory provisions permitting coverage of case management and targeted case management as optional services under a State Medicaid plan, in accordance with sections 1905(a)(19) and 1915(g) of the Act"). Unlike the managed care regulations in 42 C.F.R. pt. 438, CMS has not chosen to extend the scope of this interim final rule to services provided through a section 1115 waiver. 67 Fed. Reg. at 40,993 (June 14, 2002).

More specifically, CMS acknowledges that the "free choice" language of the interim final rule does not supersede the effect of a section 1115 waiver. 72 Fed. Reg. at 68,080 ("Absent a waiver to the contrary, those individuals also maintain their right to choose qualified providers."). Furthermore, the preamble reaffirms the existing exception from free choice for managed care under the State Plan (42 C.F.R. § 431.51(b)(1)) and under section 1115 waivers (42 C.F.R. § 431.51(c)(3)). Regarding duplication of services, the preamble states: "an individual receiving [case management services as part of managed care services] through a managed care plan may also receive case management or targeted case management services when the individual is eligible for those services." 72 Fed. Reg. at 68,a085.

Provisions of the Interim Final Rule

There are several aspects of the interim rule that would be detrimental to the effective implementation of managed care if applied to the medical management activities of MCOs, PIHPs, and PAHPs. In particular, the requirement for the prohibition on use of case management as part of the service authorization process and the limitation of one case manager per enrollee. Arizona proposes that the definition of case management be modified to exclude the medical management activities of managed care entities. In addition, the regulations should be modified in specific instances regarding free choice, service authorization, limits on the number of case managers, and claiming for case management services. These changes are necessary to explicitly recognize that medical management activities by

managed care entities, while similar in form to case management services under section 1915(g), serve a fundamentally different purpose from services under that section.

Despite the above-cited acknowledgements by CMS of the unique nature of managed care activities, there are certain statements in the preamble that cloud that acceptance and should be clarified. Specifically, the preamble states that case management may not be used to limit access to services because States may use section 1915(b) waivers or primary care case management services under section 1905(a)(25) for purposes of service authorization. 72 Fed. Reg. at 68,083. Also, the preamble states that "the decision to authorize the provision of a service must remain with the State Medicaid agency as required by § 431.10(e)." 72 Fed. Reg. at 68,084. These statements are incomplete because they fail to encompass any managed care system under 42 C.F.R. pt. 438. See specifically, 42 C.F.R. § 438.210 regarding the obligation of managed care entities to authorize services. Because of the potential for misinterpretation and the importance of medical management to managed care, we are requesting clarification.

Definition of Case Management Services - § 440.169

Arizona proposes that this regulation be modified to add a new subsection (f) that explicitly states that "case management services" do not include the activities of MCOs, PIHPs, and PAHPs to implement mechanisms for assessing, identifying, producing service plans, or monitoring service plans regarding the medical and social needs of enrollees even if, in the course of performing those activities, the managed care entity also engages in activities described in subsection (d).

Limitations on Case Management Services - § 441.18

Arizona proposes that subsection (c)(1) be modified to state that this limitation does not apply to "case management services" excluded under the proposed new subsection (f) to § 440.169; that is, to the activities of MCOs, PIHPs, and PAHPs to implement mechanisms for assessing, identifying, producing service plans, or monitoring service plans regarding the medical and social needs of enrollees.

In addition, Arizona proposes that subsection (a)(8)(vi) be clarified to make explicit the exclusion of payment through capitated arrangements by stating that the State Plan must specify the fee-for-service rates that providers will be paid.

Finally, Arizona proposes that this regulation be modified to add a new subsection (e) that states that requirements of this regulation do not apply to "case management services" excluded under the proposed new subsection (f) to § 440.169; that is, to the activities of MCOs, PIHPs, and PAHPs to implement mechanisms for assessing, identifying, producing service plans, or monitoring service plans regarding the medical and social needs of enrollees.

Thank you for accepting and considering our comments.

Sincerely,

Anthony D. Rodgers
Director

C: Steve Rubio
Meredith Meyari
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